[Cite as *Greenberg v. Ohio State Univ. Hosp. E.*, 2014-Ohio-5970.]

Court of Claims of Ohio
The Ohio Judicial Center
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www.cco.state.oh.us

ROBERT GREENBERG, et al.

Plaintiffs

v.

OHIO STATE UNIVERSITY HOSPITAL EAST

Defendant

Case No. 2012-02836

Judge Patrick M. McGrath

DECISION

{¶1} Plaintiffs [1] filed this action alleging medical negligence based upon treatment provided to plaintiff, Robert Greenberg, at Ohio State University Hospital East (OSU).[2] The issues of liability and damages were not bifurcated for trial and the case proceeded to trial on the issues of liability and damages.

{¶2} The evidence presented at trial established that on March 21, 2011, at around 12:00 a.m., after watching an athletic event on television, plaintiff, who was 83 years old at the time, began exercising by repeatedly stepping on and off a step in a hallway of his home. As he was exercising, plaintiff slipped and fell, fracturing his hip. Plaintiff testified that he was unable to get back up on his own. Using his cellphone, which was nearby, plaintiff telephoned his son, Peter Greenberg,[3] for assistance. Shortly after arriving, Greenberg telephoned for emergency assistance. Plaintiff was subsequently transported by squad to OSU where he was evaluated in the emergency room and scheduled for surgery later in the day to repair his hip. Plaintiff testified that he had not eaten anything subsequent to dinner at around 6:00 or 7:00 p.m. the previous day.

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[1]Plaintiff shall refer to Robert Greenberg. Plaintiffs shall collectively refer to Robert and Peter Greenberg.

[2]Stephen Greenberg filed a voluntary dismissal on July 13, 2012.

{¶3} Prior to surgery, plaintiff was evaluated by orthopedic surgeon, Michael Quackenbush, D.O., who, after obtaining a history and performing a physical exam, noted that plaintiff had suffered an intertrochanteric hip fracture on the left. Dr. Quackenbush also noted that plaintiff had a number of comorbidities, including congestive heart failure, coronary artery disease, ankylosing spondylitis, chronic obstructive pulmonary disease (COPD), and gastroesophageal reflux disease (GERD). Dr. Quackenbush testified that he planned to repair plaintiff's hip fracture using a metal plate and screw. Plaintiff was also evaluated for surgery by cardiology and internal medicine specialists. Additionally, plaintiff was seen by anesthesiologist Steven Beckley, M.D., who also noted some of the same comorbidities that had been noted by Dr. Quackenbush.

{¶4} Plaintiff was ultimately cleared for surgery by all specialties and the initial anesthesia induction began at around 1:00 p.m., approximately 12 hours after plaintiff arrived at the hospital. For the surgery, plaintiff was supine on a traction table with his left arm placed across his chest. Dr. Beckley was assisted by certified registered nurse anesthetist (CRNA), Patty Moomaw, and both were positioned at the head of the table, near plaintiff's head. Dr. Beckley and Moomaw began administering the anesthesia induction agents: fentanyl, a synthetic morphine used for pain medication; rocuronium, a muscle relaxant, or paralytic; propofol, an anesthesia induction agent; and lidocaine to prevent lung reflexes. Dr. Beckley testified that immediately after giving the induction medications, plaintiff regurgitated "bilious" or "green-like fluid." Dr. Beckley quantified the aspirated fluid as a "gross" amount that filled plaintiff's mouth. Dr. Beckley turned plaintiff's head to the side, performed suctioning of the mouth, and placed an endotracheal tube with the assistance of a GlideScope. The GlideScope is equipped with a fiber optic camera allowing the physician to visually confirm proper placement of the endotracheal tube below the vocal cords and above the carina. Dr. Beckley testified that he was able to visually confirm proper placement of the endotracheal tube.

{¶5} After placement of the endotracheal tube, Dr. Beckley performed further suctioning with a smaller catheter placed into the endotracheal tube. Dr. Beckley testified that by using the small catheter he was able to suction "bilious secretions" past the end of the endotracheal tube into the left and main stem of plaintiff's airway. Dr.

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[3]Greenberg shall refer to Peter Greenberg.

Beckley also placed additional IVs, an orogastric tube to prevent further regurgitation, and an arterial line to obtain blood gas values. Specifically, Dr. Beckley wanted to see if plaintiff desaturated or began having trouble ventilating. Dr. Beckley testified that he also had a discussion with Dr. Quackenbush about plaintiff's status and whether it was appropriate to continue with the surgery or postpone the surgery. According to Dr. Beckley, he informed Dr. Quackenbush that if they were going to postpone surgery, plaintiff would not be ready for surgery for 72 hours or possibly even a week.

{¶6} Plaintiff's blood gas test produced a PO2 of 183, which, according to Dr. Beckley, is outside the normal range for a patient receiving 100 percent oxygen. Dr. Beckley asserted that plaintiff's blood gas levels were somewhat of a concern, but that it was something he believed he could closely monitor while safely continuing with the surgery. Additionally, Dr. Beckley stated that plaintiff's blood gas levels were no worse than he expected them to be. After obtaining plaintiff's blood gas values, Dr. Beckley felt that the risk of postponing surgery was greater than the risk associated with proceeding with surgery. Dr. Beckley made the decision to proceed with surgery about 50 minutes after plaintiff regurgitated. Dr. Beckley testified that he made such a decision in an attempt to prevent plaintiff from developing additional complications.

{¶7} While preparing for surgery, Dr. Quackenbush learned that plaintiff had aspirated during induction. Dr. Quackenbush testified that while Dr. Beckley tended to plaintiff, he continued to check the status of his tools and equipment for surgery. Dr. Quackenbush testified that, at some point after plaintiff regurgitated, he and Dr. Beckley discussed whether surgery should be delayed; however, he was unable to recall whether they discussed any time period within which surgery would need to be completed. According to Dr. Quackenbush, it is optimal to repair a fractured hip within 24 to 48 hours of the time of the fracture. After a delay of approximately one hour, Dr. Quackenbush learned from Dr. Beckley that plaintiff was stable and that it was safe to proceed with the surgery. The surgery itself was uneventful and Dr. Quackenbush successfully repaired plaintiff's hip.

{¶8} Following surgery, plaintiff was transported to the intensive care unit (ICU) where he suffered a number of post-surgery complications including cardiac arrest approximately one hour after surgery, respiratory failure, tracheostomy placement, metabolic encephalopathy, kidney failure, incontinence, placement of a feeding tube, and deconditioning. Plaintiff remained hospitalized at OSU for approximately one

month and then spent the next six months recovering in various acute care and skilled nursing facilities including Select Specialty Hospital, Wexner Heritage House, Grant Medical Center, and OSU Dodd Hall. Plaintiff was finally released to return to his home on October 19, 2011. Greenberg subsequently moved in with plaintiff to assist in his daily care. Greenberg testified that plaintiff needed assistance with daily life activities such as getting dressed, bathing, and walking. Plaintiff is currently receiving part-time in home care provided by Peggy Triplet.[4] Plaintiff testified that he requires daily assistance both moving about the apartment and with household chores such as cleaning, laundry, and meal preparation. Plaintiff maintains that he led a relatively independent, active lifestyle prior to the surgery and that he is now largely confined to his home, requiring assistance with various daily life activities.

{¶9} Plaintiffs argue that Dr. Beckley breached the standard of care by (1) failing to appropriately treat the aspiration prior to surgery and by (2) erroneously informing Dr. Quackenbush that plaintiff was stable and that it was safe to proceed with surgery. Additionally, plaintiffs argue that the adverse outcome and post-surgical complications that plaintiff suffered would have been prevented if Dr. Beckley had complied with the standard of care. Plaintiffs seek damages totaling $758,121 for various hospital and medical expenses, household services, and noneconomic damages for both plaintiff and Greenberg. Defendant argues that plaintiffs failed to establish either a breach of the standard of care or proximate cause of any injury as a result of any alleged breach.

{¶10} "In order to establish medical malpractice, it must be shown by a preponderance of the evidence that the injury complained of was caused by the doing of some particular thing or things that a physician or surgeon of ordinary skill, care and diligence would not have done under like or similar conditions or circumstances, or by the failure or omission to do some particular thing or things that such a physician or surgeon would have done under like or similar conditions and circumstances, and that the injury complained of was the direct result of such doing or failing to do some one or more of such particular things." *Bruni v. Tatsumi*, 46 Ohio St.2d 127 (1976), paragraph one of the syllabus. The appropriate standard of care must be proven by expert testimony. *Id.* at 130. "[E]xpert opinion regarding a causative event, including alternative causes, must be expressed in terms of probability irrespective of whether the

[4] Plaintiff testified that Triplet was recently hospitalized and that his former daughter-in-law, Jennifer, has been assisting him in her absence.

proponent of the evidence bears the burden of persuasion with respect to the issue." *Stinson v. England*, 69 Ohio St.3d 451 (1994), paragraph one of the syllabus.

{¶11} In a medical malpractice action premised on a failure to properly diagnose or treat a medical condition that results in a patient's injury, the proper standard of proof on the issue of causation is whether with proper diagnosis and treatment "the condition probably would have been better but for defendant's negligence." *Miller v. Paulson*, 97 Ohio App.3d 217, 222 (10th Dist.1994). "'Probably' is defined as 'more likely than not' or a greater than fifty percent chance." *Id*., quoting *Cooper v. Sisters of Charity of Cincinnati, Inc.*, 27 Ohio St.2d 242, 253-254 (1971).

{¶12} Plaintiffs presented the expert testimony of Louis Brusco, M.D., a board-certified physician in internal medicine and anesthesiology. Dr. Brusco is currently the chief medical officer and medical director of St. Luke's Roosevelt Hospital in New York. Dr. Brusco testified that the standard of care requires that a patient be in optimal condition prior to a surgery. Dr. Brusco explained that optimal condition means that the patient is in the best shape that a patient can be in for the surgery. Dr. Brusco did not criticize the care provided to plaintiff prior to plaintiff's aspiration or for the aspiration itself; however, Dr. Brusco testified that plaintiff was not in optimal condition for surgery after the aspiration. Such a conclusion was based upon plaintiff's blood gas levels that were obtained subsequent to plaintiff's aspiration. According to Dr. Brusco, plaintiff's oxygen concentration or PO2 of 183 while receiving 100 percent oxygen means that plaintiff's lungs were having trouble transporting oxygen from the air into the bloodstream. Dr. Brusco testified that plaintiff's PO2 of 183 was caused by the aspiration. Dr. Brusco asserted that a score below 300 is the beginning of lung dysfunction and is consistent with adult respiratory distress syndrome (ARDS); however, Dr. Brusco conceded that plaintiff's blood gas levels may have been improved had the blood gas been drawn 15 minutes later. Additionally, Dr. Brusco acknowledged that plaintiff's blood gas levels were similar to those during a 2008 heart surgery.

{¶13} Dr. Brusco also testified that the blood gas tests produced additional abnormal numbers. Dr. Brusco asserted that plaintiff's pH level, which represents the amount of acid in the blood, was abnormally low at 7.29 and that the pCO2 of 56, or the amount of carbon dioxide in the blood, was abnormally high. Dr. Brusco believed that plaintiff's blood gas levels were consistent with respiratory acidosis which, according to

him, was caused by the aspiration. Therefore, Dr. Brusco concluded that plaintiff was not a stable patient after the aspiration.

{¶14} According to Dr. Brusco, the standard of care required Dr. Beckley to stop the surgery and treat the aspiration by removing the materials from the lungs. Dr. Brusco testified that the proper treatment of a patient who aspirates is to get the patient to cough up the aspirated fluid through a technique called "pulmonary toileting." Dr. Brusco explained that the treatment is performed by banging on the patient's back or chest, stimulating the patient to cough up the material from the lungs and suctioning the expelled contents; however, Dr. Brusco had no opinion as to how much aspirated fluid had entered plaintiff's lungs, where any aspirated fluid may have been located, or how much aspirated fluid would be expelled through such a technique. Dr. Brusco asserted that plaintiff should have been removed from the operating room, allowed time for his neuromuscular blockade to wear off, and received treatment for his lungs. Dr. Brusco believed that the proposed treatment would have run its course and plaintiff would have returned to the operating room approximately six hours later. As a result, Dr. Brusco believed that Dr. Beckley's decision to proceed with surgery fell below the standard of care.

{¶15} Dr. Brusco testified that Dr. Beckley failed to inform Dr. Quackenbush of the need to treat plaintiff's aspiration and erroneously informed Dr. Quackenbush that plaintiff was stable such that surgery could safely proceed. However, Dr. Brusco admitted that the anesthesiologist determines whether a patient is stable such that surgery can safely proceed. Additionally, Dr. Brusco acknowledged that even if a surgery is stopped and the aspiration is treated, the patient can still get worse; however, Dr. Brusco testified that statistics suggest that plaintiff would have improved by undergoing his proposed therapy. Dr. Brusco further admitted that the longer the delay in repairing the hip, the risk of complications increases. According to Dr. Brusco, plaintiff's post-operative complications such as cardiac arrest, kidney failure, loss of bowl function, and encephalopathy were caused by Dr. Beckley's failure to postpone the surgery and properly treat plaintiff's aspiration. Therefore, Dr. Brusco concluded that but for Dr. Beckley's breach of the standard of care, plaintiff would not have encountered the postoperative complications that he ultimately suffered.

{¶16} Defendant presented the expert testimony of David Warner, a board-certified anesthesiologist and professor of anesthesiology, neurobiology, and

surgery at Duke University Medical Center. Dr. Warner is a former board examiner and is a member of a number of professional organizations and international committees, has published more than 400 medical articles, and lectures at institutions around the world. Dr. Warner's testimony sharply contrasted with the testimony of Dr. Brusco. Dr. Warner testified that an aspiration is a recognized risk of anesthesia, although its occurrence is rare. According to Dr. Warner, once a patient that has been anesthetized has regurgitated, the standard of care requires that the anesthesiologist turn the patient's head to the side, suction the patient's airway, place the endotracheal tube and provide further suctioning—all of which were performed by Dr. Beckley. Dr. Warner testified that the endotracheal tube has a balloon on the end that inflates to prevent material from entering the lungs. Dr. Warner explained that if the patient is awake, the patient's protective reflexes will prevent the regurgitated contents from entering the lungs by vomiting; however, a patient that has been anesthetized does not have the ability to protect the airway. As a result, the standard of care requires that the anesthesiologist intervene principally by suctioning the airway followed by prompt intubation and further suctioning through the endotracheal tube. Dr. Warner testified that Dr. Beckley performed such steps and that such treatment met the standard of care.

{¶17} Dr. Warner asserted that plaintiff was stable when Dr. Beckley made the decision to proceed with the surgery. Dr. Warner explained that blood gasses are sometimes obtained during surgery to monitor pulmonary function. Dr. Warner cautioned, however, that a PO2 only measures the dissolved oxygen, which, he asserted, is less than one percent of the oxygen in the blood. Dr. Warner explained that most of the oxygen in the blood is attached to the hemoglobin, which a blood gas does not measure. Dr. Warner testified that plaintiff's blood gas levels were not too low for Drs. Beckley and Quackenbush to proceed with the surgery. According to Dr. Warner, plaintiff's PO2 level of 183 appears to be a baseline number for plaintiff given his preexisting lung disease. Dr. Warner opined that plaintiff had a PO2 of 200 while in the emergency department prior to surgery. Such a conclusion was based upon plaintiff's average pulse oximeter readings while in the emergency department. Dr. Warner explained that the pulse oximeter can be used with reasonable accuracy to determine the percentage of hemoglobin that is saturated with oxygen and, therefore, a PO2 value. Dr. Warner testified that plaintiff's oxygen saturation level in the

emergency department was in the high 80s and low 90s; whereas, normally, a patient with no lung dysfunction would have an oxygen saturation of 98 or 99. Therefore, Dr. Warner concluded that plaintiff had a preexisting lung disease. Dr. Warner attributed plaintiff's reduced lung capacity to his two disease processes: ankylosing spondylitis, which prevents his chest from moving while he breathes, and COPD, probably resulting from plaintiff's smoking history.

{¶18} According to Dr. Warner, the majority of anesthesiologists would have proceeded after initial treatment of the vomiting and regurgitation of stomach contents. Dr. Warner testified that whether to proceed or delay a surgery at that point is a judgment call to be made by the anesthesiologist; however, Dr. Warner asserted that he would have proceeded with the surgery inasmuch as plaintiff has a broken hip that needs to be treated. Dr. Warner further testified that Dr. Beckley exceeded the standard of care by placing additional IVs, obtaining blood gasses, and monitoring the patient for an hour prior to resuming surgery. Dr. Warner explained that after the aspiration, there were no good options inasmuch as plaintiff had a severe lung injury and an unstable hip. Dr. Warner asserted that at that point the chances of a good outcome were low. According to Dr. Warner, the expectation at Duke University Medical Center is that hip fracture surgeries are to be performed within 24 hours of the fracture. Therefore, Dr. Warner concluded that Dr. Beckley met the standard of care.

{¶19} Regarding Dr. Brusco's opinion that the standard of care required Dr. Beckley to stimulate plaintiff to cough up any contents in the lungs, Dr. Warner testified that the plan was "feasible" but that the likelihood of it occurring was "zero." Dr. Warner explained that when a patient aspirates, it takes time for the lung to declare the extent of the injury. Dr. Warner testified that plaintiff's aspiration was severe and that the damage was already done inasmuch as the aspirated fluid had already made contact with plaintiff's lungs and that plaintiff would have been unable to cough for approximately one hour. As a result, Dr. Warner believed that Dr. Brusco's proposed treatment would have been unsuccessful inasmuch as the damage to plaintiff's lung tissue had already occurred.

{¶20} Dr. Warner further testified that Dr. Brusco's proposed treatment would have resulted in plaintiff getting worse, not better. Dr. Warner opined that the decision to proceed to surgery did not contribute to plaintiff's post-surgical complications in the ICU given that damage had already occurred to plaintiff's lung. Dr. Warner asserted

that if the surgery had been postponed, plaintiff would not have been ready for surgery for a week, and that it was likely that plaintiff would have deteriorated during that week long period. Such a conclusion was based upon plaintiff's actual course in the ICU following surgery. According to Dr. Warner, the primary danger in postponing the surgery is not fixing the hip. As a result, Dr. Warner concluded that Dr. Beckley's decision to proceed with surgery did not proximately cause plaintiff's post-surgical complications.

{¶21} Regarding the decision of whether to proceed to surgery, orthopedic surgeon, Lawrence Wise, M.D., chief of orthopedics at the Veterans Administration Hospital in West Haven, Connecticut, testified that it is the anesthesiologist's decision as to whether to proceed with surgery after the aspiration. According to Dr. Wise, if an anesthesiologist believes there is reason to delay the surgery, then the orthopedic surgeon should comply with the request. However, Dr. Wise cautioned that hip fracture patients have a 20-30 percent mortality risk. Dr. Wise asserted that patients who are taken to the operating room within 48 hours of the fracture fair better postoperatively than patients who are taken to the operating room after 48 hours. Additionally, patients with few medical comorbidities or well-managed comorbidities tend to be part of the group of patients who fair well, while patients who have medical comorbidities that are not managed well tend to fair worse. Dr. Wise attributed such a dichotomy to the latter group being comprised of sicker patients preoperatively rather than to any delay in surgery. However, Dr. Wise admitted that a delay in surgery of "many days or weeks" increases the risk of medical complications. Dr. Wise testified that a patient that has a significant aspiration of gastric contents will require a longer term of hospital care and rehabilitation and suffer worse outcomes than patients who do not aspirate. Dr. Wise asserted that there are some patients who suffer from medical comorbidities prior to surgery who never regain their preoperative strength and stamina.

{¶22} Regarding the time frame in which orthopedic surgeons strive to repair hip fractures, defendant presented the testimony of Charles Clark, M.D. Dr. Clark is a board-certified, endowed professor of orthopedic surgery at the University of Iowa and is a board examiner for the American Board of Orthopedic Surgery. According to Dr. Clark, the time frame within which surgeons strive to repair hip fractures has shifted over the course of his career. Dr. Clark asserted that at the beginning of his career it was not unusual for patients to be immobilized until there was an opening in the

surgeon's operative schedule. Now, however, the goal is to get the patient to the operating room within 24 hours or as soon as possible. Dr. Clark explained that the reason for the push to surgery is because of the increased risk of complications such as deep vein thrombosis, pulmonary emboli, and bed sores. Dr. Clark asserted that such a push to surgery is even more important in a geriatric patient such as plaintiff because of increased risk of pneumonia and bed sores. Dr. Clark testified that, as a result, the standard of care is to complete the surgery for a geriatric patient as quickly as possible. Dr. Clark testified that plaintiff needed to be in surgery as soon as possible within that same calendar day because of increased risk factors such as his age, smoking history, and multiple comorbidities. Dr. Clark conceded, however, that orthopedic surgeons should defer to the anesthesiologist as to whether the patient is stable such that they may safely proceed with surgery.

{¶23} Dr. Clark testified that if plaintiff's surgery would have been delayed for 72 hours or more after the aspiration, plaintiff would have suffered an adverse effect. Dr. Clark testified that a patient like plaintiff would have a longer rehabilitation period than a younger patient and that there are patients who have independent functioning prior to surgery who do not return to their pre-injury condition. Dr. Clark asserted that older patients and those with comorbidities tend to be associated with reduced functioning post-surgery. Dr. Clark testified that plaintiff was a patient "right on the edge" even though he was functioning independently prior to surgery. As a result, Dr. Clark opined that plaintiff was a high-risk patient and that he was surprised that plaintiff survived all of his complications. Therefore, Dr. Clark concluded that had plaintiff's surgery been postponed, the risks of complications and mortality would have increased.

{¶24} Regarding plaintiff's post-operative function, internal medicine and geriatrics physician, Steven D'Amico, M.D., testified that 50 percent of patients who fall never return to their pre-injury level of activity and 90 percent of patients over the age of 80 who could climb stairs pre-injury are unable to climb stairs post-injury as well as they could pre-injury. Dr. D'Amico opined that because of multiple comorbidities, plaintiff had a more difficult time healing than the average 83-year-old would have had. Dr. D'Amico asserted that even without having suffered a cardiac arrest, plaintiff would have had a three to six month recovery period, extended stay in a rehabilitation center, and home health care. Dr. D'Amico opined that plaintiff's comorbidities, specifically his ankylosing spondylitis, caused a longer recovery period; however, Dr. D'Amico admitted

that the cardiac arrest in the ICU caused plaintiff a cascade of problems. Similarly, James Powers, M.D., a physician board-certified in physical rehabilitation, testified that had plaintiff not suffered a cardiac arrest, he would have had a shorter hospital stay and a shorter recovery period than what he experienced. Dr. Powers attributed plaintiff's post-surgical complications to the cardiac arrest. Dr. Powers admitted, however, that plaintiff's motion was restricted compared with the average person of his age and that a surgeon typically will operate on a broken hip unless there is some "terrible" reason why they could not.

{¶25} Upon consideration of the evidence, the court finds that plaintiffs have failed to prove their claims by a preponderance of the evidence. Specifically, the court finds that after an aspiration upon induction, the standard of care requires that an anesthesiologist turn the patient's head to the side, suction the airway, and intubate the patient followed by additional suctioning. Such treatment was performed by Dr. Beckley and CRNA Moomaw. There is no dispute that such treatment provided to plaintiff met the standard of care up to this point.

{¶26} Regarding how to proceed after initial treatment of the aspiration, the court finds the testimony of Dr. Warner to be more persuasive than that of Dr. Brusco. The court notes that Dr. Warner has impeccable credentials and has published extensively in the medical field. Dr. Warner credibly testified that after initial treatment of an aspiration upon induction, the majority of anesthesiologists would have proceeded with surgery. As explained by Dr. Warner, the damage was already done inasmuch as the aspirated fluid had already made contact with plaintiff's lungs. Dr. Brusco disagreed with such a position and testified that plaintiff's lungs were instantly inflamed but not necessarily damaged. Dr. Brusco believes that pulmonary toileting would have improved plaintiff's lungs. However, Dr. Brusco's proposed therapy would not have begun for the 30 to 60 minutes necessary to allow the anesthetics to wear off.

{¶27} Dr. Warner believed that plaintiff would not have improved quickly had the surgery been postponed. Dr. Warner drew such a conclusion based upon plaintiff's actual course in the ICU following surgery. The importance of proceeding with the surgery was emphasized by the testimony of the other doctors in this case. Indeed, each doctor who testified recognized the importance of repairing plaintiff's hip as soon as possible due to the increased risk of complications associated with a delay in surgery, especially in geriatric patients. The court is persuaded by the testimony of Dr.

Clark that the modern approach to treating hip fractures is to treat such fractures within 24 hours of the fracture where possible.

{¶28} Dr. Brusco's opinion that plaintiff was unstable and required immediate treatment of his lung injury prior to surgery to repair his hip is largely based upon plaintiff's PO2 of 183. However, as Dr. Warner explained, such a blood gas appears to be a baseline for plaintiff. Such a conclusion was based in part upon Dr. Warner's calculations of plaintiff's PO2 while in the emergency department. Furthermore, Dr. Warner noted plaintiff suffered from reduced lung capacity because of ankylosing spondylitis and COPD. Moreover, Dr. Brusco acknowledged that plaintiff had similar blood gas levels in a 2008 heart procedure. Therefore, the court concludes that plaintiffs have failed to prove that defendant committed a breach of the standard of care by going ahead with the surgery.

{¶29} Regardless of whether Dr. Beckley waited six additional hours and performed Dr. Brusco's proposed therapy, the court is persuaded by the testimony of Dr. Warner that the damage to plaintiff's lungs occurred once the regurgitated contents made contact with plaintiff's lungs. While Dr. Brusco's proposed therapy of "pulmonary toileting" may have been possible, the court is persuaded that such a proposed therapy would have increased the risk of harm to plaintiff. Indeed, Dr. Clark credibly testified that postponing surgery increases the risk of complications such as deep vein thrombosis, pulmonary emboli, pneumonia and bed sores. The risk is further increased in geriatric patients like plaintiff. Dr. Warner credible testified that had Dr. Beckley postponed surgery and performed Dr. Brusco's proposed therapy, plaintiff's condition would have deteriorated. As stated previously, such a conclusion was based upon plaintiff's actual course in the ICU. Although Dr. Brusco testified that he believed plaintiff would have been ready to return to surgery after six hours of treatment, the court finds that testimony to be more speculative and thus, less credible, as Dr. Brusco did not know where the aspirated fluid was located in the lungs or how much material would have been expelled under such a proposed therapy.

{¶30} Moreover, in view of the unknowns as to the aspirated fluid, the court finds it unclear how Dr. Brusco determined that plaintiff would be optimal after six hours. Indeed, Dr. Brusco admitted that he was guessing as to the required amount of time necessary for plaintiff to improve and that his opinion regarding plaintiff's lungs improving with his proposed therapy was based more upon statistics rather than the

specific facts of this case. Drs. Beckley and Warner both credibly testified that had plaintiff's surgery been postponed, he would not have been able to return to surgery for at least 72 hours and possibly even one week. Such a situation would have indisputably increased the risk of further complications. Accordingly, the court cannot find that plaintiff would have been better had Dr. Beckley postponed surgery to treat plaintiff's aspiration. In short, plaintiffs have failed to prove by a preponderance of the evidence that proceeding with the surgery without waiting an additional six hours and without engaging in pulmonary toileting proximately caused plaintiff's post-surgical complications.

{¶31} Based upon the foregoing, the court concludes that the care provided to plaintiff was reasonable and met the standard of care. Therefore, the court concludes that plaintiffs have failed to prove their claims of medical malpractice by a preponderance of the evidence. Inasmuch as plaintiffs have failed to prove their claims of medical malpractice, the loss of consortium claim must also fail. *Bowen v. Kil-Kare, Inc.,* 63 Ohio St.3d 84, 93 (1992). Finally, although Count Two of plaintiffs' complaint alleges a claim for lack of informed consent, plaintiffs did not present any evidence or argument in support of such a claim. Based upon the foregoing reasons, judgment shall be entered in favor of defendant.

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PATRICK M. MCGRATH
Judge

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OHIO STATE UNIVERSITY HOSPITAL EAST

Defendant

Case No. 2012-02836

Judge Patrick M. McGrath

JUDGMENT ENTRY

{¶32} This case was tried to the court on plaintiffs' claims of medical malpractice. The court has considered the evidence and, for the reasons set forth in the decision filed concurrently herewith, judgment is rendered in favor of defendant. Court costs are assessed against plaintiffs. The clerk shall serve upon all parties notice of this judgment and its date of entry upon the journal.

_____
PATRICK M. MCGRATH
Judge

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